APPLICATION FOR CHANGE OR ADDITION OF SUPERVISING PHYSICIAN FOR PHYSICIAN ASSISTANTS

State Form 42907 (R3 / 2-06)
Approved by State Board of Accounts, 2006

PHYSICIAN ASSISTANT COMMITTEE
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2060
E-mail: pla3@pla.IN.gov
www.pla.IN.gov

* Your Social Security number is being requested by this state agency in accordance with I. C. 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.

FOR OFFICE USE ONLY	
Date received (*month, day, year*)	Fee amount received
Receipt number	Application number
Certificate number issued	Date issued (*month, day, year*)

TO BE COMPLETED BY THE PHYSICIAN ASSISTANT (*please print clearly in ink*)			
Name (*last, first, middle*)			
Address (*number and street or rural route*)			
City		State	ZIP code
Social Security number *	Date of birth (*month, day, year*)	E-mail address	Telephone number (*daytime*) ( )
Certificate number		Date of issue (*month, day, year*)	Date of expiration (*month, day, year*)
Are you applying for a change of supervising physician? ☐ Yes ☐ No		Name of supervising physician prior to completion of this application	
Name of new supervising physician		Date of discontinuation of supervision of physician (*month, day, year*)	
Office address of new supervising physician (*number and street, city, state, and ZIP code*)			
Specific reason for discontinuation of supervision:			
Are you adding a supervising physician? ☐ Yes ☐ No		Name of additional supervising physician	
Office address of additional supervising physician (*number and street, city, state, and ZIP code*)			
I hereby swear or affirm under the penalties of perjury, that the statements made in this application are true, complete and correct.			
Signature of Physician Assistant			Date (*month, day, year*)

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency, any files, documents, records or other information pertaining to the undersigned requested by the Agency, or any of its authorized representatives in connection with processing my application for certification as a Physician Assistant.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned organizations, persons and institutions any information which is material to my application, and I hereby specifically release the Agency and the Committee from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force as the original.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

Signature of Physician Assistant	Date (*month, day, year*)

SUPERVISING PHYSICIAN'S STATEMENT

Name of supervising physician (*last, first, middle*)		Social Security number *
License number	Date licence issued (*month, day, year*)	Date license expires (*month, day, year*)
Residence address (*number and street or rural route, city, state, and ZIP code*)		
Office address (*number and street or rural route, city, state, and ZIP code*)		
Residence telephone number ( )	Office telephone number ( )	E-mail address
Date of birth (*month, day, year*)	Place of birth	

DOCTOR OF MEDICINE / OSTEOPATHIC DEGREE GRANTED BY

Name of school	Location	Date of graduation (*month, day, year*)

POST GRADUATE MEDICAL / OSTEOPATHIC EDUCATION AND TRAINING

INSTRUCTIONS: Include ALL internships, residencies and / or fellowships in the United States and Canada.

NAME OF SCHOOL / HOSPITAL	LOCATION	FROM (*month, year*)	TO (*month, year*)

INSTRUCTIONS: Give a description of your practice, areas of specialization and / or board certification.

JOB DESCRIPTION FOR THE PHYSICIAN ASSISTANT

INSTRUCTIONS: ON A ATTACHED SHEET, give a description of the exact privileges and tasks the physician assistant shall be performing under the physician's supervision. In addition, please give a detailed description of the process maintained for evaluation of the physician assistant's performance. THIS JOB DESCRIPTION MUST BE ON COMPANY LETTERHEAD, INCLUDING FACILITY ADDRESS AND TELEPHONE NUMBER, BE SPECIFIC TO THE APPLICANT, AND BE SIGNED BY BOTH THE PHYSICIAN AND THE PHYSICIAN ASSISTANT.

LIMIT ON PHYSICIAN ASSISTANT SUPERVISION

As a supervising physician, I understand that I may supervise no more than two (2) physician assistants. Please indicate below the name and certificate number of the physician assistant(s) you are currently supervising, if any.

CERTIFICATION OF SUPERVISION

Please indicate by signing your name below that the physician assistant named in this application will be under your continuous supervision in accordance with IC 25-27.5-6 and 844 IAC 2.2, and that you shall review all records of patient encounters maintained by the physician assistant within 24 hours after the physician assistant has seen a patient and at all time retain professional and legal responsibility for the care rendered by the physician assistant.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

Signature of Supervising Physician	Date (*month, day, year*)

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency, any files, documents, records or other information pertaining to the undersigned requested by the Agency, or any of its authorized representatives in connection with processing my application for Supervising Physician.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned organizations, persons and institutions any information which is material to my application, and I hereby specifically release the Agency and the Committee from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force as the original.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

Signature of Supervising Physician	Date (*month, day, year*)